STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155679	A. BUILDING 00 B. WING	03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHLEHEM WOODS NURSING AND REHABILITATION CENTE	4430 ELSDALE DR FORT WAYNE, IN 46835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00105419. Complaint IN00105419-Substantiated. Federal/state deficiencies related to the allegations are cited F 309. Unrelated deficiency is cited. Survey date: 3/26, 27, 2012 Facility number: 000260 Provider number: 155679 AIM number: 100267820 Survey team: Ann Armey, RN Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 13 Medicare: 54 Other: 19 Total: 86 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based on past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post surevy revist on or before April 1, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on March 30, 2012 by Bev Faulkner, RN			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interviews, and record review, the facility failed to ensure staff were aware of the location of all suctioning equipment and that compatible canisters were readily available for use which resulted in delay of suctioning for 1 of 1 resident reviewed, who required suctioning, in a sample of 4 residents with the potential to affect other residents who could potentially require emergency suctioning. (Resident #B) Findings include: 1. On 3/26/12 at 9:15 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #B required suctioning recently and had been hospitalized for aspiration pneumonia. The clinical record of Resident #B was reviewed on 3/26/12 at 11:00 a.m., and indicated the resident was admitted to the facility with diagnoses including but not limited to, dementia, hypertension and	F0309	F0309 It is the practice of this provider that all residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident number B's progress notes, physicians orders, and reports upon re-admission were reviewed by the Director of Nursing and the entire clinical team. Careplans and resident profiles were updated with diet change accordingly. All updates are available in the clinical record and care assignments are readily available to direct care staff. All suction equipment and compatible canisters are available in multiple facility locations. All licensed nursing staff are trained and knowledgeable to the location and usage of suction equipment.How other residents having the potential to be affected	04/01/2012

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	depression. On 3/20/12 at 9:50 p.m., nursing notes indicated "writer witnessed resident coughing in hallway at 7p. resident (sic) stated didn't (sic) feel well. Nursing brso (breath sounds) gurgles. PRN brtx. (breathing treatment) administered. resident was coughing up clear white secretions. writer suctioned resident with tonsil tip several pieces of chicken removed. resident with emesis times 3 color dark brown. resident stated felt SOB (Short of Breath). NP (Nurse Practitioner) notified order received to send to (Hospital) ER (Emergency Room). DON (Director of Nursing)/family notified. resident transported by EMS (Emergency Medical Services)...." The Transfer Form, dated 3/10/12 at 8:25 p.m., indicated the reason for transfer was "c/o (complaints of) SOB (Shortness of Breath) noted post choking on dinner." On 3/11/12 at 3:46 a.m., nursing notes indicated the resident was admitted to the hospital for "dx (diagnosis) SOB (Shortness of Breath) and aspiration." A Modified Barium Swallow Study Report, done at the Hospital, dated 3/13/12, indicated Resident #B had		by the same deficient practice will be identified and what corrective actions will be taken:All residents have the potential to be affected by the alleged deficient practice. Licensed nurse in dining room for all meals. All employees will be notified of any altered diet or fluid changes via resident profiles and neighborhood meetings. Careplans will be updated to reflect changes. Education to all nurses was completed on 3/28/12 by the Director of Nursing and Assistant Director of Nursing. Education included: location of suction equipment, proper assembly of all suction equipment with return demonstrations, proper pressure setting, where additional suction supplies can be found, who to contact if suction supplies need replenished, and the suction instruction manual What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:The suction machines located in the main dining room and Auguste's cottage are labeled. The unit manager audit form was updated to include daily monitoring of suctioniong equipment in all three locations to ensure all necessary equipment is available and functioning properly. Education to all nurses was completed on 3/28/12 by the Director of Nursing and Assistant Director of Nursing. Education	

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	recurrent silent aspiration with the ingestion of thin liquids. The Hospital Discharge Summary, dated 3/13/12, indicated the resident had a discharge diagnosis of aspiration pneumonia. On 3/13/12 at 5:00 p.m., nursing notes indicated the resident returned to the facility at 4:30 p.m. Physician orders, dated 3/13/12, indicated the resident, who previously had been on a regular NAS (No Added Salt) diet, was placed on a mechanical soft diet with nectar thick liquids and was to be evaluated by speech therapy. On 3/26/12 at 12:30 p.m., the resident was observed at the noon meal. She received thickened fluids. Resident #B fed herself and did not cough or choke during the meal. On 3/26/12 at 1:50 p.m., RN #10, who was working on 3/10/12, at the time of the incident involving Resident #B, was interviewed. She indicated she was standing at the medication cart in the hall with LPN #11, when Resident #B came out of her room. RN #10 indicated the resident had a deeper voice and was "gurgling." The RN		included: location of suction equipment, proper assembly of all suction equipment with return demonstrations, proper pressure setting, where additional suction supplies can be found, who to contact if suction supplies need replenished, and the suction instruction manual. All outdated equipment was removed. Suction equipment instructions are with each suction machine. All new hires will recieve training on location and use of suction machines in addition to skills validation already included in the new hire packet.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed: Daily audits of suctioniong equipment in all three locations will be conducted by the unit manager to ensure all necessary equipment is available and functioning properly and turned into Director of Nursing. Data will be submitted to the CQI team if the 100% threshold is not met, an action plan will be developed. Quarterly refresher in-services on emergency equipment will be conducted. All changes were completed on 3/28/2012 and in-servicing will be an ongoing measure to ensure compliance. Non-compliance with facility policy/procedure may result in disciplinary action and/or	

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	indicated the resident needed to be suctioned so she went to get the suction machine, while LPN #11 remained with the resident. She indicated she got the suction equipment from the nursing supply closet and returned to the hall but the canister she brought did not fit the machine so they ended up calling another nurse (LPN #12), who got a different suction machine from the main dining room. RN #10 estimated there was about a ten minute delay before they were able to suction Resident #B with the second machine. RN #10 indicated she was new and, at the time of the incident, she was not aware that their were several suction machines available in the facility. On 3/26/12 at 2:45 p.m., LPN #11, who was working at the time of the incident, was interviewed. She indicated Resident #B came out of her room, had a frothy substance down her shirt and said she was not feeling well. LPN #11 indicated she told RN #10 the resident needed to be suctioned and RN #10 went to get a suction machine. LPN #11 indicated the canister RN #10 grabbed was not compatible with the suction machine so another nurse, LPN #12, brought a suction machine from the main dining room. She indicated she was able to suction out a hunk of chicken and		re-education.	

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	the resident felt better. LPN #11 indicated, a short time later, Resident #B felt like there was something still in her throat so she was sent to the hospital for an evaluation. LPN #11 estimated it took five to ten minutes from the time she determined the resident needed suctioning until the second suction machine was obtained. LPN #11 indicated, during this time, Resident #B was able to talk, was not turning blue and had stable vital signs. On 3/26/12 at 6:20 p.m., LPN #12 was interviewed. LPN #12 indicated she was the evening supervisor, but was working on the cart in the Secure Unit at the time of the incident. LPN #12 indicated she was called to help after the nurses had problems with the first suction machine. She indicated Resident #B was gurgling and she agreed the resident needed suctioning so she obtained a suction machine from the main dining room. She indicated she assembled the suction machine and LPN #11 suctioned the resident. On 3/27/12 at 9:00 a.m., the DON (Director of Nursing) indicated she was told the nurses had trouble with the suction canister but they were able to get another suction machine. The DON indicated they checked the supplies, the			

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	following day, and there were plenty of suction canisters available. 2. On 3/26/12 between 9:20 a.m. and 9:50 a.m., accompanied by the ADON the following was observed: In the main dining room, there was a portable suction machine in a cupboard. The suction machine, cord, canister, and tubing were in a portable canvas tote. There were no operational instructions with the suction equipment. On the Secured Unit, there was a portable suction machine in a drawer at the nurses station. There was no sign indicating the suction machine was located in the drawer. There were no operational instructions with the suction machine. On the crash cart, by the nurses station at the front of the building, there was a suction machine, cord, canister and tubing. An instruction manual was with the suction machine that was enclosed in a plastic bag. In the Nursing Supply Closet, there were 7 canisters sets that were compatible with the suction machines on the units. There were also several suction canisters, that according to the ADON, were not compatible with the suction machines on			

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	the units. On 3/26/12 at 9:50 a.m., the staff person responsible for medical supplies indicated she checked the equipment on the crash cart every day but she did not check the suction equipment in the main dining room or on the Secured Unit. On 3/26/12 at 4:15 p.m., the staff person responsible for the medical supplies indicated she could not find the instruction manuals for two of the suction machines. On 3/26/12 at 10:15 a.m. and 12:35 p.m., RN #13 and #14 were interviewed separately about the location of the suction equipment. RN #13 indicated the suction machine in the main dining room was located in the kitchen and RN #14 thought the suction equipment was located in the medical supply closet and on the crash carts but indicated he would have to ask to be sure. Three nurses, LPN #15, #16, #17, were interviewed separately on 3/26/12 at 1:00 p.m., at 4:00 p.m. and at 4:10 p.m. respectively. The nurses indicated they had not used the suction equipment in some time and felt they would benefit from some training regarding the assembly of the suction equipment.			

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	This Federal tag relates to Complaint IN00105419. 3.1-37(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interviews and record review, the facility failed to assure a resident's feet were on the wheelchair foot rests while being transported in the wheelchair. This deficiency affected 1 of 1 residents reviewed who had fallen from the wheelchair in a sample of 4. (Resident #E) Findings include: On 3/27/12 at 9:05 a.m., accompanied by the DON (Director of Nursing), Resident #E was observed in his wheelchair just prior to entering the Secured Unit. The resident had sutures above and below his left eye. The DON indicated the resident fell out of his wheelchair. The resident was returning from an appointment and the resident's wheelchair was being pushed down the hall on the secure unit by CNA #18. The resident's wheelchair had foot rests, but his left foot was not on the foot rest and was intermittently dragging on the floor.	F0323	F0323 It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.What corrective actions will be accomplished for those residents found to have been affected by this deficient practice:An additional positioning device was placed on w/c pedals to ensure residents feet stay properly positioned on w/c foot pedals. CNA # 18 received a performance improvement plan ensuring all fall interventions are being followed.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All residents dependent on staff for w/c mobility have the potential to be affected by the alleged deficient practice. All residents using wheelchairs were audited for the need for additional assistance devices. Any resident identified with a need was addressed with careplan updates. Education was completed by the Director of Nursing and Assistant	04/01/2012

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	The clinical record of Resident #E was reviewed and indicated the resident was admitted to the facility on 2/22/12, with diagnoses which included but were not limited to, dementia with delusions. The MDS (Minimum Data Set), dated 3/5/12, indicated the resident required extensive assistance with transfer, locomotion, and dressing. On 3/20/12 at 7:20 p.m., nursing notes indicated a CNA (Certified Nursing Assistant) was assisting the resident to his room. The note indicated "While pushing wheelchair, resident put both feet down on floor firmly. Resident fell forward and hit head on the floor..." The note indicated the resident sustained a laceration above his left eye brow and was being sent to the hospital for evaluation. The transfer form, dated at 3/20/12 at 7:26 p.m., indicated the resident was transferred to the hospital. The emergency room report, dated 3/20/12, indicated, Resident #E had an 8 cm laceration over the left eye that was closed with suture and a 0.5 cm laceration over the left maxillary area that was also closed with suture. No other injuries were noted.		Director of Nursing to all nursing staff on 3/27/12 regarding accidents and supervision with a focus on w/c safety. A daily audit tool was initiated to check for placement and function of all assitance devices.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education was completed on 3/27/12 regarding accidents and supervision with a focus on w/c safety. A post-test was administered to evaluate effectiveness of education. A daily audit tool was initiated on fall interventions to check for placement and function. This audit will be utilized by the nurse managers randomly on all three shifts. Any interventions found not to be in place will be corrected immediately and education will be provided. Careplans are audited quarterly and with any significant changes to ensure accuracy. Daily rounds to be completed by nurse managers.How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed: A CQI monitoring tool titled Resident Care Rounds will be utilized by DNS/ADNS weekly x 4, monthly x 6, and quarterly thereafter. Data will be submitted to the CQI team if the	

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	On 3/21/12 at 4:12 a.m., nursing notes indicated the resident returned to the facility. Interdisciplinary Notes, dated 3/21/12 at 6:52 a.m., indicated "Team recommends initiating foot pedals to w/c (wheelchair) at all times and front anti tippers to w/c..." The fall risk care plan, dated 3/3/12 was updated, on 3/21/12, to include "foot pedals on w/c at all times" and "front anti tippers to w/c." On 3/27/12 at 3:20 p.m., The ADON indicated all staff were being inserviced regarding the safety of residents, who were being transported in the wheelchair. 3.1-45(a)(2)		100%threshold is not met, an action plan will be developed. Non-compliance with facility policy/procedure may result in disciplinary action and/ or re-education.	